Opposing Practice Location Restrictions for Graduating Canadian Medical Students

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Position Paper

CFMS Canadian Federation of Medical Students
FEMC Fédération des étudiants et des étudiantes en médecine du Canada

Briefing Note

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Summary

One strategy imposed by provincial governments to address the longstanding issue of underserviced rural communities involves the utilization of practice location restricting contracts. In recent years, contracts have surfaced that require newly graduated Canadian medical students (CMGs) to relocate to an underserved area immediately upon graduation for a set number of years and impose strict penalties if the conditions of the contract are not met. These contracts have been implemented into existing residency positions that were previously unrestricted. This paper explores the issues surrounding the use of this specific type of contract (the "ROSTERP") and posits that is a poor strategy in tackling the challenges of underserved areas. This paper also seeks to discuss the implications of placing these contracts on newly graduated CMGs, and the financial and social repercussions inherent therein. We believe that these contracts are detrimental to Canadian medical students while also failing to address the challenges faced by underserved communities. In lieu of these restrictions, we call on governments and postgraduate medical faculties to address the root causes of rural/urban health disparity and to increase efforts to train students from rural communities. These models have been proven to work, and do not rely on the forced relocation of urban students to rural areas, an ultimately harmful and ineffective practice.

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Introduction/Background

*ROSTERP = “Return of Service Contracts Tied to Existing Residency Positions”

Throughout Canada, there has long existed an uneven distribution of physicians serving its communities. Rural areas in Canada constitute 18% of the Canadian population, but are served by only 8% of the physicians practicing in Canada.[1,2] Due to various geographic, environmental and systemic factors, Canadians living in rural areas continue to face numerous barriers in accessing healthcare. In fact, in 2014, the College of Family Physicians of Canada (CFPC) and the Society of Rural Physicians of Canada (SRPC) formed a joint task force solely with the goal to improve the health of rural Canadians.[3]

Among the strategies used by governments to increase physician services in rural communities are practice location restricting contracts. These have been labelled with different names in the past, but a common term is a “Return of Service” (ROS) contract. An ROS contract is an agreement typically undertaken by a medical trainee or a physician new to practice in Canada, which imposes an obligation to work in an underserved area for a set number of years in exchange for a specific residency position, monetary compensation, or loan forgiveness. Specific ROS obligations vary from province to province and eligibility criteria differ based on level of training.

Although traditionally meant for International Medical Graduates (IMGs) looking to relocate to Canada and obtain full medical licensure, ROS contracts have also began being tied with Canadian Medical Graduates (CMGs). In 2018, as a response to advocacy efforts by medical students to increase residency spots, the Ministry of Health and Long-Term Care in Ontario created 53 new one-time residency positions with all of them tied to an ROS contract.[4] Recently, select second iteration spots in CaRMS across Canada added an ROS contract tied to their programs.[5] Subseqently, in the 2018-2019 CaRMS cycle, a first iteration dermatology residency spot in British Columbia was tied to an ROS contract.[6] Now, in the upcoming 2019-2020 CaRMS cycle, additional ROS spots have been tied to multiple first iteration CMG spots, including anesthesiology, emergency medicine, and dermatology from Dalhousie University, and family medicine from Northern Ontario School of Medicine.[5] These positions are Return of Service contracts tied to existing residency positions, or “ROSTERP.”

Data has shown that contracts which impose a restriction on where physicians can work are ineffective long-term strategies that fail to address underlying issues of poor retention in underserviced areas. IMGs who accept ROS contracts have an incredibly high turnover rate.[7,8] It has been shown that IMGs will often agree to complete their training in certain underserved areas of Canada as “entry-points” to obtain full licensure in Canada, and leave once their contract is over.[7,8] Additionally, it has been demonstrated that postgraduate training location is a significant predictor of future work location among CMGs, particularly in rural areas. A study of physicians who graduated from Memorial University of Newfoundland between 1973 and 1998 showed that over 95% of those who remained working in Newfoundland and Labrador by 2004 were actually originally from Newfoundland and Labrador.[20] Furthermore, although it was demonstrated in a similar study that medical trainees who take their ROS agreements in Newfoundland and Labrador do complete their service commitments in full, it was revealed that

most physicians who made this choice wanted to work in these underserved communities in the first place.[21] Overall, these data illustrate that ROS contracts have been used for various purposes over time showing some benefits in certain provinces in Canada.

A 2013 study on Newfoundland's "Return-for-Service (RFS)" program demonstrated that when these RFS agreements were offered as optional, bursary-type incentives (rather than a contractual obligation with a financial penalty if not agreed to), retention rates for physicians to stay in Newfoundland were much higher. In general, RFS agreements linked to bursary were more effective than RFS agreements linked to residency position funding.[22] Overall, it is important to recognize that service in rural areas needs to occur, and there may be certain circumstances in which a contractual obligation may be necessary and beneficial.

Thus, the CFMS understands that recruitment in underserviced areas is an issue, but an approach converting existing residency positions (the ROSTERP) is a targeted, unsustainable solution that is taking advantage of Canadian medical students who are vying to match in an increasingly competitive process. We do not wish to place all ROS contracts as a whole under a spotlight. However, a discussion on ROS contracts as a whole is beyond the scope of this paper, since a great diversity of ROS contracts exist in Canada, each with their own specific restrictions and limitations, benefits, and challenges, which cannot all be generalized together.

The creation of the University of British Columbia's (UBC's) distributed medical education model, which offers medical training sites in rural locations (Prince George, Kelowna) is an example of an approach to alleviate the issue of underserviced areas. These sites offer a preference for selection of medical students who have a background of living or working in rural areas through a supplemental application that calculates a candidate's "rural suitability score."[16] Similarly, the existence of the Northern Ontario School of Medicine also attracts rurally-born and rurally-raised Canadians to a school that trains students in a rural environment, with the prospect that they will continue their career in a rural area. Effort and trust should be placed into more initiatives such as these, which have been shown to work. In fact, data from the UBC Faculty of Medicine demonstrates that the distributed medical education model is having a positive impact on the supply of primary care physicians as well as rural physicians in British Columbia. Of all students trained in a rural setting at UBC (such as Prince George or Kelowna), 59% went into Family Medicine, and 66% pursued training in a rural setting.[17]

For historical context, the issue of provincial governments instituting controversial policies to improve healthcare presence in rural communities is not new. In 1997, a lawsuit was filed against the Medical Services Commission of British Columbia by the Professional Association of Residents in BC (PAR-BC, now known as Resident Doctors of BC) for the creation of "restricted billing numbers". Similar to ROS contracts, this was an attempt to relieve medically underserved areas. Under this model, new physicians who received a billing number after the year 1994 would receive a "restricted billing number." This meant they could only receive 50% of their billing amounts if they were servicing an "over-serviced"/urban area but would receive 100% of their billings if servicing an "underserved"/rural area. This lawsuit eventually escalated to the Supreme Court of British Columbia where it was found to be in violation of the Canadian Charter of Rights and Freedoms - specifically Section 6, Mobility Rights.[12] As a result, the new measures introduced by the Medical Services Commission were ultimately struck down.[13,14]

The ROS contracts currently offered in the first iteration of the CaRMS match similarly restrict the portability of the medical profession and physicians' right to move within Canada, and thus can potentially be subject to similar legal challenges.

It is unreasonable for provincial governments to attempt to place the burden of healthcare delivery and distribution onto newly graduated medical students. Because medical students are facing increased pressures at matching to a residency, some students may apply for a ROSTERP residency position out of fear of going unmatched - although this can, in part, be mitigated with proper career counselling from schools recommending students to not rank placements they do not want to match to. However, with fear acting as a motivator to accept a ROSTERP contract and no true desire to work in a rural area following full licensure, the ROSTERP model has the potential to exacerbate the "revolving-door" in rural healthcare delivery and further contribute to the stigma of rural medicine as an undesirable medical practice option. This is unfavourable to patient care, as continuity of care has been well-documented in the literature to be beneficial and associated with lower morbidity and mortality rates.[10,11] Unequal healthcare distribution is an age-old issue in Canada, and it requires tangible government action at many levels to resolve the issue. Solely targeting newly trained physicians to work a ROSTERP contract provides a temporary solution with minimal long-term viability.

Due to the cost of medical education, the amount of student debt accrued by medical students is consistently very high. For most students, provincial student loans and personal savings are not able to cover all costs, so students seek out lines of credits from banks. This debt is another primary driver of why medical students are seeking to match to residencies, as receiving payment in residency will help to begin paying down their medical student debt. However, under the ROSTERP contract terms from first iteration spots in the CaRMS match for CMGs, if a trainee breaks their ROSTERP contract, they would have a contractual obligation to pay a large fee. As an example, for the dermatology ROSTERP contract introduced in the 2018-2019 year in the 1st iteration of CaRMS, the "repayment on termination" amount was $979,581 - nearly 1 million dollars.[7] This is an exorbitant fee to pay for any working professional, much less a medical trainee with a large amount of debt. Additionally, it is not uncommon for trainees to change their field of practice and switch residencies. This is permitted by postgraduate faculties because they recognize it is highly undesirable to force a trainee to complete a residency that they do not want. However, these ROSTERP contracts contain no such provision and thus any attempt to switch residency, or any inability to complete the residency besides grievous injury or death, results in the full bill owing. We believe such terms of contract restrictions have the potential to negatively impact the health and wellness of students who may experience unexpected life events.

Please note that as this position paper is presented to the CFMS (Canadian Federation of Medical Students), it is meant to advocate specifically for Canadian medical students, as we are only able to speak to the unique experience of Canadian medical students. This paper is thus speaking against ROSTERP for CMGs.

Principles/Stance

The CFMS endorses the following principles in support of a stance discouraging the conversion of existing unrestricted residency spots to residency spots tied with practice location restrictions targeted at newly graduated CMGs.

1. ROSTERP is not an appropriate or sustainable solution to the current issue of rural and underserved areas. This model has the potential to contribute to a lack of proper long-term care for patients in rural areas, communicates an inaccurate negative message about rural medicine, and places an inappropriate burden on Canadian medical students, inappropriately limiting their freedom of movement and negatively impacting their financial and emotional wellbeing.

2. Increased, action-oriented effort should be placed on exploring alternative solutions to serving the healthcare needs of rural and remote areas.

3. Advocacy efforts from the CFMS and medical student societies should be directed at increasing transparency and collaboration with their respective provincial governments when discussing the terms and implementation of existing ROSTERP

Concerns

Concern 1: ROSTERP is increasingly being tied to existing residency positions for CMGs, yet are ineffective in achieving a sustainable solution for underserviced areas.

ROSTERP has increasingly been introduced for CMGs, now in multiple different programs and different schools during the first iteration of the CaRMS match. There is significant concern that this will continue to spread to other programs in other provinces. As more and more contracts become established, it will normalize the practice of restricting mobility of new CMGs and could potentially create a system where Canadian-trained physicians cannot expect any control over their location of practice once graduating residency. This is a violation of physicians' freedoms and efforts must be made to prevent these contracts from increasing and spreading to other medical programs across Canada.

Concern 2: Contractually obligating Canadian medical students entering the CaRMS match to serve rural areas may appear to resolve the issue of underserved areas but are only exacerbating issues of long-term healthcare delivery in rural areas.

As mentioned earlier, effort should be placed in initiatives that have been shown to work (such as the models mentioned at UBC and the Northern Ontario School of Medicine). The issue with these initiatives is that, while more effective, they take time to display results, whereas a contract forcing relocation to an underserved is an immediate "guarantee" to secure physicians in places of need. In the grand scheme, however, focus should be placed on initiatives that are sustainable and beneficial for all parties - both patients and future physicians. The increasing

use of ROSTERP may impede efforts in addressing the true underlying causes for a lack of physician presence in rural areas.

Concern 3: In implementing ROSTERP contracts, medical students were not involved in the conversation, demonstrating poor transparency in the process.

The creation of ROSTERP occurred without any consultation from medical students, and yet, medical students are those who are directly affected by this decision. It is well documented that medical students experience extreme burnout and higher rates of depressive symptoms and suicidal ideation compared to the general population.[18, 19] ROSTREP has the potential to affect the ability of medical students to attain stability, to start families, and to create lasting roots in a community if they are created without medical student input. The medical profession is already a career path that provides very delayed gratification and requires immense personal sacrifice. As a result, it is not unreasonable to ask that medical students sit in on conversations regarding the implementation of practice location restricting contracts such as ROS and ROSTERP.

Recommendations

1. In any future initiatives aimed at lobbying provincial governments regarding residency spots, medical student societies should seek support from their faculty, provincial, and resident medical associations, and any necessary regulatory bodies to present a unified stance discouraging the addition of ROSTERP for Canadian medical students.

    a. Additionally, medical student societies should strive to communicate with their provincial governments, PTMAs, or any relevant regulatory bodies prior to the addition to any new residency positions that are tied to a Return of Service Contract and offer the perspectives outlined in this position paper.

2. Advocacy efforts from medical student societies should focus on other strategies to increase physician recruitment to underserved areas, as well as novel approaches to provide rural areas with an appropriate level of service.

    a. This includes increased establishment and enrolment of students into medical education models that train medical students from rural communities within rural communities, which have shown to be effective in recruitment to underserviced areas. Increased effort should be placed on immersive rural exposure during medical school consistently across all schools in Canada.

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